Norwood Green Care Home

Norwood Green Care Centre

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

There was a registered manager at the service at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

This was an unannounced inspection. Prior to this inspection, the service was last inspected by the Care Quality Commission on 5 November 2013 and at the time was found to be meeting the regulations we looked at.

Norwood Green Care Centre provides accommodation for up to 92 people who require nursing or personal care.

Summary of findings

There are three units within the home. Two of the units are for people living with the experience of dementia. The third unit is for people that have general nursing care needs. There were 84 people using the service when we visited.

People told us they felt safe and we saw there were systems and processes in place to protect them from the risk of harm.

People's needs were assessed and care plans were developed to address the identified needs. Risks were assessed and reviewed regularly and appropriate management plans were in place where risks were identified to ensure people's safety. Staff spoke confidently about understanding people's needs and treating each person as an individual. There were sufficient numbers of staff to meet people's individual needs.

People were involved in making decisions about their care and how they wanted to be cared for. Staff had undertaken training on the Mental Capacity Act 2005 and were aware of their responsibilities in relation to Deprivation of Liberty Safeguards (DoLS).

Recruitment practices were robust and being followed. People received effective care from staff who were trained and supported by the manager.

People were involved in the assessments of their health and care needs and in developing and reviewing their care plan. Life history information, including individual preferences, had been obtained and this allowed staff to have a better understanding of people's needs.

Suitable arrangements were in place to ensure people's nutritional needs were met according to their choices and preferences.

People had access to health and social care professionals to meet their needs and staff monitored their health and wellbeing. Where people required equipment to maintain their safety and independence, this was provided.

People's care records had been reviewed regularly so any changes to their care were identified and records were kept up to date. People and their families said they would be confident to raise any concerns that arose and we saw that complaints were investigated and responded to in accordance with the complaints procedure.

There were effective systems in place to monitor and improve the quality of the service provided. A programme of audits was carried out and where shortfalls were identified, actions plans were in place to make improvements. People's views were sought both on an informal and formal basis.

This was through talking to people and their representatives on a day to day basis, during their reviews of care, through the use of surveys and quarterly meetings. The staff described the service as having an open and transparent culture. The manager demonstrated good leadership skills and was supportive to people using the service, relatives and staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People who used the service told us they felt safe. Risks to people had been assessed and reviewed regularly to minimise these and to ensure people's individual needs were being met safely.

Safeguarding and whistleblowing procedures were in place and staff were clear about reporting any suspicions of abuse. The service had effective recruitment processes in place and undertook full employment checks when recruiting new care workers.

When people did not have the ability to make decisions about their own care the staff followed the legal requirements that ensured decisions were made in people's best interests. Staff were aware of their responsibilities in relation to the Mental Capacity Act 2005 and DoLS.

Is the service effective?

Good

The service was effective. People's health and social care needs were assessed, and staff provided the care and support they required, according to their care plans.

Staff were trained to deliver care safely and to an appropriate standard. Staff demonstrated a good understanding of people's care and support needs and they knew them well.

People had access to healthcare professionals to meet their needs and the service worked well with other healthcare professionals to coordinate people's care.

Is the service caring?

Good

The service was caring. Staff treated people in a gentle and caring manner when they supported and assisted them with their care. People's privacy and dignity were respected.

Care plans provided staff with guidance on how to support people with their care needs. People and their relatives told us they were involved in making decisions about their care.

Staff had a good understanding of people's diverse needs and how these were valued and respected.

Is the service responsive?

Good

The service was responsive. Care was planned and people were supported in a way that suited their individual needs and preferences. The provider had an activities programme and people were able to participate in activities that they enjoyed.

People were encouraged to express their views and make suggestions about improvements to the service. Arrangements were in place for people to provide feedback about the care and support they received. They were made aware of the complaints procedure and complaints were responded to appropriately.

Is the service well-led?

Good

The service was well- led. The provider regularly assessed and monitored the quality of the service provided. Staff were clear about the values of the organisation and spoke confidently about caring for people in an individual and safe manner.

Summary of findings

The registered manager was experienced and knew the service well. She demonstrated good leadership skills, was approachable, open and provided an inclusive culture at the service.

The service used best practice guidance to implement improvements in care.

Norwood Green Care Centre

Detailed findings

Background to this inspection

We undertook an unannounced inspection of Norwood Green Care Centre on 1 August 2014. The inspection team included two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority safeguarding team to obtain their feedback on the service. No concerns were raised in the feedback they provided.

People who used the service had complex needs. Therefore we used a number of different methods to help us understand their experiences of using the service, including the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people.

We spent time observing care in the communal areas such as the lounge and dining area, we carried out a tour of the premises and we looked in detail at nine care plans and other documents and records that related to people's care and the management of the home.

We spoke with 20 people who used the service, eight relatives and 15 members of staff.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective? '

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. One person said, “The staff aren’t bad, they’re very good.” Another person said, “The staff are friendly, generally they look after me well, unless they’re in a hurry and have other things to do.” A relative told us, “I think they’re [the staff] quite exceptional. Whenever a carer comes in [my relative’s] face lights up. I know I can trust them.”

We viewed nine people’s care records. These included risk assessments such as moving and handling assessments, the likelihood of developing pressure damage, falls and nutritional assessments. Where risks had been identified plans were in place, which provided staff with guidance about how to minimise the risks whilst balancing the person's right to make choices and to maintain their independence. For example, all care records we viewed had a moving and handling assessment in place. The assessment was comprehensive and identified the type of hoist and slings that were to be used to ensure the person was moved safely. Staff we spoke with told us they had sufficient equipment to move people safely.

Where people were at risk of choking due to swallowing difficulties, detailed guidelines were in place to minimise the risk. For example one person was provided with food which was pureed because they could not swallow solids safely. Risk assessments were regularly reviewed to ensure they were effective and addressed the current risks to promote people’s health and safety.

There were effective recruitment and selection processes in place. We viewed four staff records which detailed that the relevant checks had been completed before staff began work. One new member of staff we spoke with confirmed that all required checks had been carried out before they commenced employment.

We observed staff attending to people in a calm, unhurried and timely manner throughout the inspection. However, some relatives and people we spoke with told us staff were busy and there were shortages of staff on some days which meant people sometimes had to wait for assistance. One person said, “When they’re short of staff, it’s a bit difficult for them, they do the best they can.” Another said, “They are short-staffed more often than not.” We spoke to the manager about staffing levels. The manager told us the staffing levels were determined according to the dependency levels of people who used the service. Records we viewed confirmed that dependency levels were assessed monthly.

At the time of our inspection the service was providing care and support to 84 people. We looked at the staff roster. There was one nurse and five care staff on each of the three units for the day shift. The manager explained that each unit was short of a nurse due to nurse vacancies. We spoke with staff who told us they were being kept informed of the recruitment plans to replace those staff who had left and that interim staffing plans were in place and working to ensure people’s needs were met. Interim plans included the use of bank and agency nurses and care staff. On the day of the inspection we saw the registered manager administered medicines on the ground floor and staff confirmed the manager assisted staff where required when there was a shortage of staff.

We spoke with members of staff about their understanding of protecting adults at risk of abuse. They had a good understanding of what safeguarding adults entailed, could identify types of abuse and knew what to do if they witnessed incidents of abuse. All the staff we spoke with told us, there was a safeguarding policy and procedure they would follow and they had received safeguarding training which also included whistleblowing. Staff training information we viewed confirmed that all staff had received safeguarding training. The provider also had a confidential whistleblowing telephone line that staff could use to report concerns. This helped ensure staff had the necessary knowledge and information to make sure people were protected from abuse. We spoke with the safeguarding team prior to the inspection and they told us the service was proactive in reporting any safeguarding concerns.

Staff had a good understanding about people’s rights, individual choices and decisions. One staff member said, “it’s about keeping [people’s] safety without intruding on their choices.” Training information and records we viewed confirmed that all staff had received training in the Mental Capacity Act and DoLS.

All the care records we viewed contained a ‘rights, consent and capacity’ document. This detailed the assessment of people’s ability to make decisions, and the importance of supporting them to do so. The assessments were carried out with their family or representative’s involvement where

Good

Is the service safe?

they did not have the capacity to make a particular decision so that decisions were made in the person's best interests. We saw that best interests decisions had been made for one person in relation to the use of covert medicine and Do Not Attempt Resuscitation. These decisions were reviewed at three monthly intervals to ensure it was still appropriate for them to be in place.

CQC is required by law to monitor the operation of the Deprivation of Liberty safeguards (DoLS).

The manager told us that following the recent High Court judgement every person's mental capacity was to be reviewed and that if restrictions that could amount to a deprivation of their liberty were identified then a Deprivation of Liberty Safeguards (DoLS) authorisation would be applied for. For example, an emergency DoLS authorisation was being applied for in relation to a person who was disorientated, to ensure their safety. The manager had also been proactive and contacted local authorities to ask what they expected in light of the court ruling.

Systems were in place for the monitoring of health and safety to ensure the safety of people, visitors and staff. For example, weekly fire alarm tests, daily health and safety walkabouts. Regular fire drills were taking place to ensure that people using the service and staff knew what action to take in the event of a fire. We saw that gas, electrical and fire safety certificates were in place and renewed as required to ensure the premises remained safe for staff and people using the service. We also saw that Legionella testing had taken place.

From records we viewed we saw that equipment, such as lifts, hoists and beds, was serviced regularly to make sure that it was appropriately maintained and safe for people. Care plans we viewed detailed the type of equipment people required to assist with their mobility, comfort and independence so staff were aware of this. The manager told us that where required people were provided with equipment to suit their individual needs. For example, the provider was introducing hoist slings and sliding sheets for each person using the service, so that the risk of accidents in relation to the use of inappropriate equipment and cross infection was minimised.

There was a business continuity plan in place for foreseeable emergencies such as fire, flood and power failure so that staff knew what action to take to protect people in these circumstances.

Good

Is the service effective?

Our findings

Staff had a programme of training, supervision and appraisal to ensure people were supported by staff who were trained to deliver care safely and to an appropriate standard. Staff told us they were encouraged to access available training, which included mandatory training such as moving and handling, safeguarding, infection control and health and safety. Staff meeting minutes we viewed for July 2014 showed that staff were also supported with their personal development to gain qualifications in care, such as National Vocational Training in health and social care. Staff we spoke with confirmed that various aspects of service provision including organisational change and care practice were also discussed during staff meetings.

We spoke with one new member of staff who told us they had undertaken a three day induction. They thought this had provided them with adequate training to start their role, They confirmed the training included health and safety, moving and handling, medicines management and fire safety. The electronic records we viewed confirmed that all staff had completed their mandatory training which included dementia care training and specific training such as palliative care and tissue viability to care and support people appropriately in the unit where they worked. All the staff we spoke with said they received regular supervision every eight weeks, which enabled them to discuss their work, any concerns they had and their professional development and training needs. Staff told us they had an annual appraisal. Staff records we viewed confirmed this. Staff also told us they received support to discuss any issues and guidance from the unit managers and heads of departments through unit staff meetings.

People's nutritional needs were assessed to identify if people were at risk of malnutrition so appropriate action could be taken to ensure their welfare. A nutritional profile had been completed for each person and included information on their dietary preferences, likes and dislikes and preferred times and place to have their meals. Copies of the profile were available in each person's care file and in their bedrooms so these were easily accessible to staff. Dietary requirements had been discussed with the kitchen staff and the cook had a list of the various diets that people required. For example, information was available if people required soft, pureed, diabetic, low salt and diets that met people's cultural and religious needs. One person told us they liked fish and chips and this was recorded on their profile.

Information about the menu was available to people so they could choose their meals. The menu was displayed in the reception area and copies were available on each unit. Three main meal choices were available which included a vegetarian option. People could also request alternatives if they did not want the main choices. To support people making choices during mealtimes staff people showed each of the two choices on a plate so they could make an informed choice about what they wanted to eat. The cook also monitored if people enjoyed their meals and made a point of getting feedback from people about the meals served to them, to make improvements where required.

We observed lunchtime on each unit. We saw that the dining areas were appropriately prepared for people to have their meals. Where people required support with their meals staff encouraging them to eat and assisting them at their own pace so they were not rushed while engaging with them. Regular dining audits were carried out by the manager to improve people's dining experience. For example, the audits we viewed detailed people's feedback that they wanted to be offered hand and oral hygiene prior to and after their meal. During our inspection we saw that this had been addressed.

People's weight was monitored monthly or weekly, depending on the outcome of their nutritional risk assessments. If concerns were identified a plan was developed to address this need and they were referred to a dietician for input. In some cases they were prescribed supplements by their GP. The cook told us of some initiatives to increase the nutritional content of meals for people at risk of malnutrition. For example, they fortified meals by adding cream and butter and provided fresh fruit smoothies. Food and fluid intake for those people who were at risk of malnutrition was monitored. The manager reported she monitored the weight of all people weekly and checked whether staff took appropriate action where concerns were noted, so people's nutritional needs were met appropriately.

We spoke with people and their relatives about the food, snacks and refreshments provided by the service. One person said, "Breakfast was lovely." Another said, "I had a

Good

Is the service effective?

good breakfast, I had porridge, then egg and beans." Someone else told us, "Some (food) I like, I like ordinary food, not spicy food, they give me ordinary food, they know I don't like spicy food."

People's health and welfare was monitored and they were referred to healthcare professionals as required. Care records confirmed that people had received input from other healthcare professionals, including GP, tissue viability nurse specialist, palliative care nurse, community psychiatric nurse, optician and podiatrist, to ensure their healthcare needs were being met. For example, we saw that the staff were following guidance from the speech and language therapist for a person who had swallowing difficulties. The GP visited the home twice weekly, they carried out reviews on people's medicines, health checks and made referrals to other professionals if required.

Good

Is the service caring?

Our findings

People's individual needs were assessed and care was planned accordingly. We viewed 10 bedrooms on one of the dementia units. All were personalised with pictures and people's belongings. Life history information was available in each person's bedroom and accessible to all staff so they could get to know the person and their background. This supported staff to build relationships and understand some of the behaviours that people displayed. One member of staff said, "We get a lot of information from people's families so we can understand who they are." Another staff member told us they had spoken with a relative regarding some gestures their family member made, and the relative was able to confirm this related to a pet the person had.

People said they received a good standard of care. One person said, "I think they do a really good job. The care has been good." Another said, "They are OK, they really help me out. I become stronger. They are like family. There are ups and downs. I have nothing to complain about." One visitor commented, "She [my relative] is treated very well. She always looks nice, has nice clothes on." Another visitor said, "I think they're quite exceptional. Whenever a carer comes in [my relative's] face lights up. I know I can trust them."

Staff respected people's privacy and dignity and their right to be involved in decisions and make choices about their care and treatment. This was confirmed by the people we spoke with. We observed that when staff supported people with their personal care needs, the bedrooms and bathrooms' doors were closed to ensure people's privacy. Throughout our inspection we saw staff interacting with people in a professional manner, laughing and chatting with people.

Staff demonstrated a good understanding of people's needs and were able to describe the care people required. We observed staff responding to people's needs promptly. For example one member of staff noted that a person's hearing aid was not positioned correctly and they re-positioned it so it was more comfortable for them. Another staff member noted that a person was watching television without their glasses and asked them if they wanted them. Staff told us they always considered and respected people's individual wishes such as when people requested care from staff of the same gender. One relative told us the staff were, "very pleasant" and "very obliging" and a person using the service said, "The care is great."

People were involved in making decisions about their care and support. We saw that people and their families had been involved in the development and review of their care and support. For example, for one person the Do Not Attempt Resuscitation (DNAR) order had been discussed with the family, individual and GP. These are decisions that are made in relation to whether people who are very ill and unwell would not benefit from being resuscitated if they stopped breathing. For another person who required bedrails to prevent them falling out of bed, discussions were held with the family prior to their use as the person was unable to consent to this decision.

People had care plans addressing their end of life care which reflected their wishes and instructions with regard to this aspect of care. The records we viewed demonstrated that the staff worked closely with the palliative care team to provide effective end of life care. Pain assessments were carried out for all people with end of life care needs and for those who required anticipatory medicines, these were available for nursing staff to administer. Care plans were in place for the management of people who had end of life care needs. These included information about their medicines regimes to manage their symptoms effectively. There was evidence that the care plans and regular medicines reviews with the GP, practice nurse and pharmacist took place for people to receive appropriate care and treatment according to their needs.

Staff had a good understanding of people's diverse needs and how these were valued and respected. We saw that people wore clothing appropriate for the time of year according to their religious beliefs and customs. For example, Sikh women wore traditional Sikh clothing, which included a headscarf. Staff had considered the backgrounds of people using the service and on the dementia units we saw that Bollywood movies posters and 'Elvis' record sleeves were displayed.

Staff supported people to maintain relationships with their family. Relatives spoken with confirmed they were kept up to date on their family member's progress by telephone or

Good

Is the service caring?

when they visited. The staff said relatives and friends could visit people during the day at any time. During the inspection, we observed staff welcoming relatives and friends that were visiting the service.

Good

Is the service responsive?

Our findings

Prior to people moving into the service pre-admission assessments were carried out by the manager or deputy manager to ascertain whether the needs of the individual could be met by the service. We saw other information was also obtained from family members and social services. Information on people's likes, dislikes and preferences and associated risks was recorded so that staff could provide individualised care. Care records provided a good picture of each person, their needs and how these were to be met. Care plans were in place for each identified need and these were reviewed monthly or whenever a person's condition changed, so the information was up to date. The service had arrangements in place to manage pressure ulcers. We viewed two wound records, which detailed the monitoring of the pressure ulcer and the action they were taking to manage the pressure ulcer. This included the input of the tissue viability nurse specialist, dietician and photographs to monitor the wound and the use of pressure relieving mattresses.

People were supported in promoting their independence according to their individual abilities. Some people were able to attend to their personal care needs. We saw that people were able made their own drinks and helped themselves to snacks, such as cake that were available. We observed staff seeking people's permission before carrying out any support for example, "Would you like to go to the garden?" and "Where would you like your lunch?"

People's religious, spiritual and cultural needs had been identified and were being respected by staff. For example, where people required specific types of food such as Halal and vegetarian this was provided. Representatives from various religious denominations visited the home to provide religious services such as Holy Communion, bhajans and kirtans (Sikh religious songs) and prayers.

Quarterly meetings took place for people living at the service and their relative's so they had an opportunity to express their views and make suggestions about improvements to the service. We viewed the minutes of the meeting held in April 2014 and attended the relatives meeting which was held on the day of the inspection. Areas discussed included staffing, cleanliness and activities for people.

People and their relatives had various opportunities to give feedback about the quality of care they received. For example, they were able to give feedback on their care and support during review meetings and direct feedback to staff on a daily basis. People could also meet the manager individually to discuss specific concerns regarding their family member.

Annual satisfaction surveys were undertaken to get feedback about the quality of the service provided. The results of the last survey in 2013 indicated that 89% of people using the service would recommend it to other people. We saw that the feedback from the surveys had been evaluated and an action plan was in place to address the shortfalls that had been identified, so that improvements could be made. For example, concerns were raised about clothing and as a result of the feedback responsibility for the return of people's laundry was given to the laundry staff.

A procedure for making a complaint or raising a concern was in place and well-publicised throughout the home, in the service user guide and on the provider's website. Information was also available on how to contact advocacy services to support people to lodge a complaint, if this was required. People told us they would speak with the manager, deputy manager and unit managers if they had any concerns. One relative told us their family member had raised concerns about the timing of their breakfast and shower. They discussed this with the staff and the concern was resolved. We viewed the complaints log. Where a complaint had been received, this had been appropriately acknowledged, investigated and the outcome communicated to the complainant.

There was an activities programme on display so that people could choose which activity to join in. Each person had an activity plan which detailed their interests and past hobbies. The activities coordinator said they arranged activities to meet people's needs and wishes and also had individual sessions with people who preferred not to join in group activities. We saw some people sitting out in the garden having tea and biscuits in the morning. People were observed chatting with staff, reading the newspaper and listening to music. In the afternoon the activity coordinator held a music and singing session which people enjoyed.

Good

Is the service responsive?

Where people were living with the experience of dementia we saw that the service had developed a sensory room, with lights, bubble tubes, music and other sensory equipment to stimulate people.

Good

Is the service well-led?

Our findings

Throughout our inspection we saw that the registered manager operated an open-door policy and the people who used the service, relatives, and staff could come in and out of her office whenever they wanted to discuss issues important to them. She told us that if the door was shut this meant that she was not available.

There was a positive and inclusive culture at the service. Staff told us they were committed to providing good quality care for people that centred on their needs. Staff morale was good and all of the staff we spoke with said they liked working at the service. The staff said they had undertaken training in dignity in care and the specialist dementia care programme. We saw positive interactions between the manager, deputy manager and staff. Staff confirmed they were kept up to date with the any changes within and challenges faced by the service and organisation. For example, they told us that staffing was an issue, but they knew that recruitment was taking place.

The home had a clear management structure in place and staff said the manager was approachable, visible and when required worked with staff to provide care and support to people. One staff member commented, “She helps at lunchtime to support people with their food.” Another said “She always comes to ask us whether we need additional support in the laundry.”

The service had a number of systems to monitor the quality of the service and to identify, analyse and review risks, adverse events, incidents and errors. These included a schedule of audits that were carried out at various intervals throughout the year. For example, the manager completed a monthly medicines, nutrition and care documentation audit. Where shortfalls had been noted, actions required to address the shortfalls were identified. These were then followed up at the next audit. The manager informed us that each unit manager was required to submit a weekly report detailing changes in people’s weight, mobility and skin condition so that she had an overview of people’s well-being and whether additional input from healthcare professionals or others was required.

The provider had in place a reporting system which was used to monitor aspects of the service including accidents, incidents, safeguarding and complaints. The manager told us that the leadership team regularly received performance information on risk and quality and were able to collate risk management information about the service or any particular individual using the service. For example, if people had pressure ulcers the actions taken by the service were recorded within the system. All accidents and incidents were recorded electronically, reviewed and monitored for any trends or patterns. Learning from incidents / investigations took place and appropriate changes were implemented. The registered manager told us that following an investigation into an incident in another service, all people using the service now had a choking risk assessment in place.

The service was working towards the PEARL (Positively Enriching And Enhancing Residents Lives) accreditation. The PEARL programme helps care services work towards a number of set criteria to ensure they provide the most up to date training, communication and interventions for people with dementia. All the care staff we spoke with told us that as part of the PEARL programme they had received training in dementia care and people received care that was person-centred and which took into account their rights and diverse needs. The deputy manager told us that they had been successful in improving people’s wellbeing, through the PEARL programme by carrying out medicines reviews and reducing the use of antipsychotic medicines to manage people’s dementia care needs.